ALABAMA MEDICAID AGENCY REFERRAL FORM

Today's Date _____ Referral Date _____

RECIPIENT INFORMATION

Recipient Name	Recipient #:	Recipient DOB:

PRIMARY PHYSICIAN	**SCREENING PROVIDER (IF DIFFERENT)**
Name:	Name:
Address:	Address:
Telephone #:( )	Telephone #:( )
Fax #: ( )	Fax #:( )
Provider #:	Provider #:
Signature:	Signature:

TYPE OF REFERRAL

❑ Patient 1st	❑ Lock-in
❑ EPSDT Screening Date _____	❑ Patient 1st/EPSDT Screening Date _____
❑ Targeted Case Management (TCM)	

LENGTH OF REFERRAL

Referral Valid for _____month (s) or _____visit (s) from referral date

REFERRAL VALID FOR

❑ Evaluation Only	❑ Treatment Only
❑ Evaluation and Treatment	❑ Hospital Care (Outpatient)
❑ Referral to other provider for identified condition	❑ Performance of Interperiodic Screening (if necessary)
❑ Referral to other provider for additional conditions (diagnosed by consultant)	

Reason for Referral:

Co-morbid Diagnosis:

CONSULTANT INFORMATION

Consultant Name: Consultant Telephone # ( )

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to primary physician.

Please submit findings to Primary Physician by:

❑ Mail	❑ Fax # ( )
❑ E-mail	❑ In addition, please telephone